STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15E209	A. BUILDING 01 B. WING	08/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMIT CONVALESCENT CENTER	701 S MAIN ST SUMMITVILLE, IN46070

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K0000	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 08/18/11 Facility Number: 000373 Provider Number: 15E209 AIM Number: 100288730 Surveyor: Phillip Komsiski, Life Safety Code Specialist At this Life Safety Code survey, Summit Convalescent Center was found not in compliance with Requirements for Participation in Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type II (111) construction and was not sprinklered. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors with battery operated detectors in resident sleeping rooms. The facility has a	K0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	capacity of 34 and had a census of 33 at the time of this survey. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 08/23/11. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			
K0029 SS=E	One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 Based on observation and interview, the facility failed to ensure 4 of 7 doors leading to hazardous areas such as Oxygen storage rooms where oxygen transfer occurs and rooms with combustible items were provided with self closing devices which would cause the door to automatically close and latch into the door frame. This deficient practice affects 10 residents on northwest hall, 9 residents on southeast hall, 2 residents observed in the lounge next to	K0029	Self-closing devices were ordered on 8/29/11, and will be installed on all 4 doors by 9/17/11.Maintenance Supervisor will ensure all self-closing devices and latching doors are closing appropriately on his quarterly preventative maintenance rounds.	09/17/2011

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	Administrative hall and 2 residents observed in the Lobby next to the Service corridor as well as visitors and staff. Findings include: Based on observation on 08/18/11 during the tour between 12:31 p.m. to 3:00 p.m. with the Maintenance Supervisor, the following doors leading to hazardous areas which were at least fifty square feet in size were not provided with door closing devices: a. The Oxygen storage room on Northwest hall where oxygen transfer occurs. b. The Supply room on Southeast hall with seventeen cardboard boxes next to room # 123. c. The supply room on Administration hall had seven carboard boxes and sixty toilet paper rolls. d. The Maintenance office on Service corridor had thirteen cardboard boxes. Based on interview on 08/18/11 concurrent with each observation with the Maintenance Supervisor, it was confirmed the aforementioned doors leading into hazardous area rooms were not equipped with a self closing device. 3.1-19(b)			

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K0054 SS=E	All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3 Based on observation and interview, the facility failed to ensure 1 of 5 smoke detectors on Southeast hall were installed in a location which would allow the smoke detector to function to its fullest capability. LSC 9.6.1.4 refers to NFPA 72, National Fire Alarm Code. NFPA 72, 2-3.5.1 requires, in spaces served by air handling systems, detectors shall not be located where air flow prevents operation of the detectors. This deficient practice could affect 9 residents on Southeast hall as well as visitors or staff. Findings include: Based on observation on 08/18/11 at 1:33 p.m., with the Maintenance Supervisor, there was one smoke detector installed within two feet of an air supply duct on Southeast hall next to room # 127. Based on interview on 08/18/11 at 1:35 p.m., it was acknowledged by the Maintenance Supervisor the single smoke detector was installed within two feet from an air supply duct in the ceiling which would not allow the smoke detector to detect smoke to its fullest capability.	K0054	All residents, staff and visitors have the potential to be affected bythis alleged deficient practice. The smoke detector on the Southeast hall was moved by the facility fire protection company on 8/31/11. Rounds were conducted by the Administrator and Maintenance Supervisor to ensure that other detectors were installed 3 feet or more from a air supply duct. One additional detector was found less than 3 feet away from an air supply duct in the front lobby. This detector was also moved by the fire protection company on 8/31/11.Maintenance Director/Designee will complete quarterly rounds to ensure that nothing is within 3 feet of the smoke detectors. POC DATE-8/31/11	08/31/2011

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	3.1-19(b)			
K0066 SS=E	Smoking regulations are adopted and include no less than the following provisions: (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking. (2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision. (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4 Based on observation, record review and interview; the facility failed to adopt smoking regulations and failed to ensure cigarette butts were deposited into a noncombustible container which was provided for 1 of 1 areas where smoking was permitted. This deficient practice could affect 8 residents on Northeast hall	K0066	An additional approved noncombustible smoking disposal container was purchased and placed off the facility property where smoking is allowed. The container where there were cigarette butts and paper products has been removed from the outside of the Northeast exit. A smoking policy was developed that states employees and visitors	09/17/2011

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	as well as visitors and staff. Findings include: Based on observation on 08/18/11 at 2:02 p.m. with the Maintenance Supervisor, the smoking area just outside the Northeast exit used a metal trash container with a self closing lid as a trash container for paper goods as well as a place to deposit sixteen cigarette butts. Based on review of facility policies on 08/18/11 at 3:02 p.m. with the Maintenance Supervisor, a smoking policy was not available to address the proper deposition of extinguished cigarette butts. Based on interview on 08/18/11 at 2:08 p.m. with the Maintenance Supervisor, it was acknowledged the facility's employees disposed of cigarette butts into an approved metal container, however, it was also used to dispose of paper products.		may only smoke off the facility property and cigarette butts shall only be disposed of in an approved container. Additionally, no paper products shall be disposed of along with smoking materials. An all staff fire safety in-service has been scheduled for 9/8/11, and fire safety as well as smoking policy and smoking material disposal will be reviewed. Department supervisors and administrator/designee will perform monthly rounds to ensure the smoking policy is being followed. POC Date 9/17/11	
K0068 SS=F	Combustion and ventilation air for boiler, incinerator and heater rooms is taken from and discharged to the outside air. 19.5.2.2 Based on observation and interview, the facility failed to ensure 1 of 1 boiler rooms on Service corridor was provided with intake combustion air from the outside for rooms containing fuel fired equipment. This deficient practice could	K0068	All residents, staff and visitors have the potential to be affected bythis alleged deficient practice. Quotes are currently being obtained from outside vendors for the installation of a fresh air intake inside the boiler room. The	09/17/2011

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	create an atmosphere rich with carbon monoxide which could cause physical problems for 2 residents observed in the Lobby as well as visitors and staff. Findings include: Based on observation on 08/18/11 at 12:57 p.m. with the Maintenance Supervisor, the boiler room on Service corrdor had two, one hundred gallon fuel fired boilers with no fresh air intake. Based on interview on 08/18/11 at 12:59 p.m., it was acknowledged by the Maintenance Supervisor the boiler room with fuel fired boilers did not have a fresh air intake. 3.1-19(b)		fresh air intake system will be installed by 9/17/11. POC: 9/17/11	
K0070 SS=E	Portable space heating devices are prohibited in all health care occupancies, except in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 degrees F. (100 degrees C) 19.7.8 Based on observation and interview, the facility failed to provide documentation for the use of 1 of 1 portable heating units used in nonsleeping staff areas. This deficient practice could affect 2 residents observed in the lobby adjacent to	K0070	The portable heating unit was removed from the MDS office on 8/18/11. The staff members occupying that office were informed that a portable heating unit was not to be used in the office. An all staff fire in-service was completed on 9/8/11 and	09/17/2011

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	Administrative hall as well as visitors and staff. Findings include: Based on observation on 08/18/11 at 1:00 p.m. with the Maintenance Supervisor, the M.D.S. office on Administrative hall contained one portable space heater which was not operating at the time. Documentation was not available to verify the heating elements did not exceed two hundred and twelve degrees F. Based on interview on 08/18/11 at 1:05 p.m. with the Maintenance Supervisor, it was acknowledged the information for the portable heating unit, though not in use, was not available for review to verify the portable heating unit did not exceed two hundred and twelve degrees F, and a portable heating unit policy was not available for review. 3.1-19(b)		staff were in-serviced that portable heating units are not allowed in a nursing facility unless the heating unit of the device does not exceed 212 degrees and documentation can be provided of this.Maintneance Supervisor/Designee will perform monthly rounds with preventative maintenance tasks to ensure no unapproved portable heating units are utilized in the facility. POC Date- 9/17/11	

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K0143 SS=E	Transferring of oxygen is: (a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction; (b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and (c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2 1. Based on observation and interview, the facility failed to ensure 1 of 1 oxygen storage rooms where oxygen transfer occurs was separated within a one hour fire barrier enclosure. This deficient practice could affect 10 residents on Northwest hall as well as visitors and staff near the oxygen storage room. Findings include: Based on observation on 08/18/11 at 1:50 p.m. with the Maintenance Supervisor, a fire rating tag could not be found on the corridor door to the oxygen transfer room on Northwest hall which could validate it was a one hour fire rated door. Based on interview on 08/18/11 at 1:52 p.m. with the Maintenance Supervisor present, it was acknowledged oxygen transfer occurs in the oxygen storage room on Northwest	K0143	The mechanical ventilation unit was repaired on 8/29/11, and the fan is working correctly. The maintenance supervisor will check the function of the fan on a weekly basis when he completes preventative maintenance rounds. Staff was in-serviced on 9/8/11 that, in the event they notice malfunction or concerns with the exhaust fan, they are to contact the maintenance supervisor immediately.Facility will ensure the door to the O 2 room will have a door with at least a 45 minute fire rating by 9/17/11. All other fire doors in the facility will be checked by the maintenance supervisor to ensure they all have the appropriate fire rating. POC Date- 9/17/11.	09/17/2011

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	hall and the corridor door to the oxygen storage room was not equipped with a fire rating tag. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 1 oxygen transfer areas had working electrically powered mechanical ventilation. This deficient practice could affect 10 residents on Northwest Hall as well as visitors and staff in the area. Findings include: Based on observation and interview on 08/18/11 at 1:46 p.m. with the Maintenance Supervisor, it was verified the oxygen storage room on Southwest Hall was used to store and transfer oxygen and was provided with electrically powered mechanical ventilation, but it was not working. Based on interview on 08/18/11 at 1:50 p.m., it was acknowledged by the the Maintenance Supervisor an electrically powered mechanical vent was not working to provide ventilation for the oxygen transfer room. 3.1-19(b)			

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K0155 SS=F	Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch is provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8 Based on record review and interview, the facility failed to provide a written policy in the event the fire alarm system is out of service for more than 4 hours in a 24 hour period for the protection of 33 of 33 residents. LSC, 19.7.1.1 requires every health care occupancy to have in effect and available to all supervisory personnel a plan for the protection of all persons. All employees shall periodically be instructed and kept informed with respect to their duties under the plan. The provisions of 19.7.1.2 through 19.7.2.3 shall apply. 19.7.2.2 requires all fire safety plans to provide for the use of alarms, the transmission of the alarm to the fire department and response to alarms. 19.7.2.3 requires health care personnel to be instructed in the use of a code phrase to assure transmission of the alarm during a malfunction of the building fire alarm system. This deficient practice could affect all residents, staff and visitors.	K0155	All residents, staff, and visitors have the potential to be affected by this alledged deficient practice. Fire alarm system policy was obtained on 8/30/11. The policy was reviewed and minor updates made. The facility policy book was updated with the policy. All charge nurse's were in-serviced on the fire alarm system policy and their responsibilities in the event the fire alarm system is out of service. An all staff fire safety in-service has been scheduled for 9/8/11, and fire safety as well as the policy in the event of interruption of the fire alarm system will be reviewed with all staff. POC Date: 9/17/11	09/17/2011

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	Findings include: Based on Fire Alarm record review on 08/18/11 at 3:37 p.m. with the Maintenance Supervisor, the facility did not have a written policy and procedure for an impaired fire alarm protection system available for review. Based on interview on 08/18/11 at 3:38 p.m. with the Maintenance Supervisor, it was acknowledged a policy which would address an impairment of the fire alarm system was not available for review. 3.1-19(b)			